MAQ

Population Reports

Organizing Work Better

Lamia Jaroudi for JHU/CCP

Contents

This issue of **Population Reports** was prepared in collaboration with the Maximizing Access and Quality (MAQ) Initiative of the United States Agency for International Development's Office of Population and Reproductive Health. The MAQ Initiative supports research and evidence-based interventions to promote access to and quality of family planning and reproductive health services.

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Family planning and other health care organizations in developing countries increasingly must do more with the same resources, and sometimes with fewer. Reorganizing work processes offers one common-sense way to help staff members at all levels cope with growing demands.

Whether you are a clinic manager, front-line provider, program supervisor, or district-level manager, you can improve how work is organized and performed. Often, simple changes enable organizations to serve clients better, offer more satisfying work to the staff, operate more effectively, cut waste, and even reduce or recover costs.

Organize Work for Greater Efficiency and Better Services

Decentralization, integration of services, the AIDS epidemic, and the increasing push to reach the poorest and most remote communities challenge health care organizations everywhere. To cope, organizations need to operate more effectively, become more efficient, and meet evolving client needs.

The organization of work approach can help. It encourages managers and service providers to see their organization as a collection of resources and processes and to ask: Do the resources and processes work together? Do they meet clients' and providers' needs? How can they work more productively? By addressing these questions, staff often can devise ways to work more efficiently and effectively. Improving the organization of work need not be time-consuming, complicated, or expensive.

Applying the Concept

In health care a focus on meeting patients' needs increasingly guides service delivery. Now, the Maximizing Access and Quality Initiative has identified nine key elements of service delivery in which the organization of work approach can be applied to better meet clients' reproductive health care needs:

Use of evidence-based practices. Organizations that base clinical practices on the best available evidence can remove needless barriers to care and deliver better quality services.

Adaptability. Foresight and flexibility enable managers to deal with the fluctuations common to health care service delivery.

Links with other services and sites. Good referral systems help organizations provide access to a complete range of services.

Minimizing paperwork, maximizing information use. Collecting and using only those data necessary to make decisions reduces time-consuming paperwork.

Physical factors. Service providers can make better use of space and resources to ensure well-organized, well-stocked, and comfortable facilities.

Service hours and scheduling. Both clients and providers benefit when scheduling takes their needs into consideration.

Client flow. Improving how clients move through the clinic can shorten waits and provide more time for clients and providers to interact.

Division of labor and job design. Service providers and managers can be more productive—and satisfied—when all know their responsibilities and have authority to carry them out.

Social factors. Leadership, staff development, and open lines of communication motivate and support the staff—a health care organization's key resource.

Getting Started

Improving organization of work requires that people look at their programs and jobs with fresh eyes, learn, and agree to work together in better ways. Good work organization results when all nine elements of service delivery are addressed, integrated, and managed as a whole. Basic principles provide practical guidance, including:

- Remove unnecessary barriers that limit care,
- Balance both clients' and providers' needs,
- Promote teamwork, not hierarchical thinking,
- Plan for common fluctuations in health care delivery,
- Deliver each service at the lowest-level facility practical,
- Empower staff to both collect and use data, and
- Use the most up-to-date interventions and approaches.

When programs apply the principles of good organization of work, they serve clients better, providers are more productive and satisfied, and resources are used more efficiently.

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Understanding Organization of Work

Many problems at the service delivery level can be best understood and solved by looking at the organization as a whole. The health care delivery system typically involves different geographic units, departments, and levels—including central, regional, and community. Thinking about the way work is organized helps managers and providers throughout the system to see their organization as a collection of interdependent resources (including infrastructure, supplies, and referral sites) and processes (such as client scheduling and information management) that change and evolve in response to both clients' and staff needs. Rather than looking at individual tools or procedures, the concept of organization of work looks at whether the different elements of an organization work together, work efficiently, and focus on both clients' and providers' needs.

In the private sector concepts that help organizations focus on improving customer service long ago superseded earlier managerial approaches that focused on carrying out tasks. In health care, too, client-oriented and service-oriented concepts, rather than task-oriented approaches, increasingly guide service delivery. Now, the Maximizing Access and Quality (MAQ) Initiative has applied the concept of organization of work to facilitate more client-oriented services in family planning and other reproductive health care.

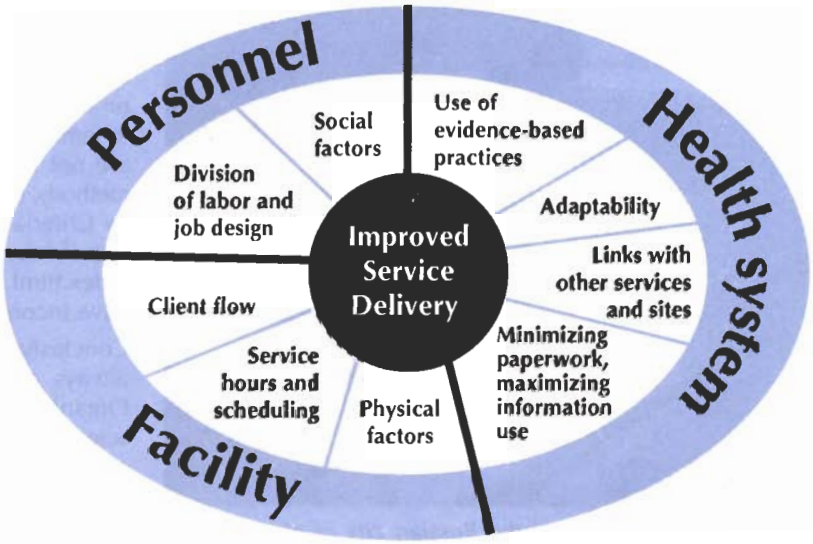
Organizing work better need not be complicated or time-consuming. Often, simple changes to processes and procedures can help address major work-related problems. For example, redistributing workloads among providers, removing unnecessary procedural steps, or performing certain tasks at the same time, rather than one after the other, can improve services and save time and money.

The organization of work concept can help address nine key elements that, when neglected, interfere with access to and quality of services. The elements apply to different levels of service delivery—the health system, the facility, and personnel (see figure, at right).

For each of these elements the MAQ Organization of Work Subcommittee has identified several basic principles to help staff make improvements. These principles reflect the experience and expert opinion of the Subcommittee. While they are drawn primarily from family planning and other reproductive health programs, they also can apply to a range of other health care delivery services.

The rest of this report consists of nine sections addressing in turn each of the nine key elements of organization of work. Each section presents and discusses the principles that guide effective performance. Also, each section contains one or more short boxes, "Principles in Action," which present brief examples from country experiences. A final section offers tips and tools to help managers and providers put the elements and principles into practice.

Figure 1. Nine Elements of Organization of Work



1. **Use of evidence-based practices**
   Applying guidance based on demonstrated impacts and eliminating unnecessary procedural barriers (see p. 4);
2. **Adaptability**
   Being flexible to meet the changing conditions common to health care service delivery (see p. 6);
3. **Links with other services and sites**
   Improving internal and external referral systems (see p. 6);
4. **Minimizing paperwork, maximizing information use**
   Collecting, recording, communicating, and applying the right information effectively (see p. 8);
5. **Physical factors**
   Encouraging staff to be resourceful when using facility space and ensuring supplies (see p. 9);
6. **Service hours and scheduling**
   Tailoring clinic hours, scheduling, and follow-up visits to meet both clients' and providers' needs (see p. 10);
7. **Client flow**
   Shortening wait times and improving traffic patterns, balancing client load and client flow (see p. 11);
8. **Division of labor and job design**
   Clearly defining staff responsibilities and functions, lines of authority, and management structures (see p. 12);
9. **Social factors**
   Providing leadership and motivation, and encouraging skill development and positive human relations (see p. 14).

1 Use of Evidence-Based Practices

Health care programs increasingly use an evidence-based approach—that is, they base guidelines, standards, and practices on scientific evidence of safety, effectiveness, and efficiency (18, 44). Adopting evidence-based procedures and practices can eliminate unnecessary barriers to care and so deliver services better (45, 104).

Michele Bertsy for JHU/CCP

In a maternity hospital in the Russian city of Novgorod, a new mother cares for her infant. In Russia and elsewhere more family planning and other health care programs are using evidence-based practices to improve quality of care.

Principles in Action

Russia: Using Evidence-Based Guidance to Improve Care While Reducing Costs

In 1998 three hospitals in Tver Oblast, Russia, used an evidence-based approach to improve care for pregnancy-induced hypertension (PIH), to reduce the number of women hospitalized for PIH, and to lower health care costs as well. Reviewing research evidence, clinical experts updated diagnostic criteria and treatment procedures. As a result of the new, more accurate diagnostic criteria, far fewer women were diagnosed with PIH needlessly—with no decline in the quality of care.

In the three hospitals the percentage of women diagnosed with PIH fell from 44% of pregnant women in 1998 to under 6% in 2000. The total number of women hospitalized for PIH in the three hospitals dropped by 77% between 1998 and 2000. In addition, the average total cost of care for hospitalization, drugs, and tests combined fell by 87% (88, 89).

Principles for Using Evidence-Based Practices

1 Use the most up-to-date interventions and approaches. Knowing and using approaches that are based on the best available evidence enable organizations to provide the most effective health care efficiently. Evidence-based guidelines—norms, standards, protocols, and practice recommendations—help health care providers make good decisions about specific aspects of care, such as diagnosing health problems or providing appropriate family planning methods (19).

The World Health Organization (WHO) has developed the Medical Eligibility Criteria, which provide guidance regarding who can safely use contraceptive methods, as well as the Selected Practice Recommendations, which provide guidance regarding how to safely and effectively use methods. This guidance is based on available evidence on the safety and use of contraceptives. It expands access to family planning services by helping ensure that people are not inappropriately denied a full choice of suitable methods. (For more information on WHO Medical Eligibility Criteria and Selected Practice Recommendations, see http://www.who.int/reproductive-health/family_planning/index.html.) Many organizations and national programs have incorporated this guidance into their standards.

Conclusive scientific studies of efficacy and safety are not always available to justify every health care practice. Organizations can try to stay up-to-date on whatever scientifically valid guidelines are available nationally, and then modify them to suit the local context and resources. In the absence of scientific evidence, organizations should continue to base practices on experience and logical assumptions or adapt practices used elsewhere. For guidance on the best available program practices, Advance Africa provides the Best Practices Compendium —an online database of proven reproductive health and family planning service delivery practices—at http://www.advanceafrica.org/compendium/.

2 Avoid unproven practices, which waste time and resources, and adopt those that have an impact. Programs that replace outdated guidelines with evidence-based practices can provide services more efficiently (see box, this page). For instance, current antenatal care practices recommend that women with a normal pregnancy visit a clinic just four times, rather than making more frequent visits routinely. A systematic review of the available evidence has found that frequent visits are unnecessary (20). They often burden the health system and take up providers' and clients' time needlessly (79, 124).

Also, new recommended practices call for families to develop birth-preparedness plans—to decide before delivery who will attend the birth, where the mother will deliver, and what to do in the event of complications. The preparedness approach replaces the "risk approach" model, which identified women with high-risk pregnancies so that they could be referred to specialized care. More than 10 years of experience has shown that risk factors fail to distinguish successfully between women who will develop complications and those who will not (102).

By using evidence-based practices, managers can avoid practices that do not work well or create unnecessary

Principles in Action

Peru: Client Exit Interviews Improve Services

In Chiclayo, Peru, the Max Salud Institute for High Quality Health Care set up a client feedback system at two clinics. At the Urrunaga Clinic client exit interviews revealed that long wait times caused much dissatisfaction.

To improve client flow and reduce wait times, the clinic started giving clients numbered tickets, color-coded according to the different types of service, as they checked in. The tickets made check-in easier and faster for the staff and let clients know the order in which they would be seen and what services they would receive. Also, the clinic provided free supplies during consultations so clients could avoid trips to the pharmacy.

Comparison between 1998 and 2000 assessments showed that the percentage of clients who waited half an hour or less to see a provider increased from 56% in 1998 to 80% in 2000. The percentage of clients who said that wait times were too long decreased from 28% to just 1% (96).

2 Adaptability

Health care organizations today face many challenges—among them the HIV/AIDS epidemic, rapid social change, shortages of staff and funding, and change within health care service delivery itself, such as decentralization. Moreover, organizations and health care providers and managers must adopt a range of approaches customized to the different needs and changing situations of different clients. Regularly consulting with clients, community leaders, policy-makers, and other key program stakeholders can help programs focus on meeting the greatest current needs.

Principles of Adaptability

1 Modify approaches as needed. Organizations need to prepare themselves for the many changes unfolding in health care to better address their clients' range of needs. To do so, they must be willing and ready to change the way they deliver services. For instance, maternity clinics in many countries must now consider how to deal with mother-to-child transmission of HIV. Also, family planning providers must alter counseling to include discussion of dual protection.

The need to make services available to people in more remote areas poses its own difficulties. Yet with foresight and adaptability programs can organize work to make services accessible and convenient. In Acarape, Brazil, for instance, the health center changed service hours to accommodate clients coming from rural areas. Staff from the center also worked with the mayor to change transportation schedules to better meet rural clients' needs (64).

2 Plan for common fluctuations in health care delivery. Every health care organization faces variation in client demand, stocks of supplies, staff availability, and other factors that affect service delivery. In fact, such changes in conditions are often the norm. Managers and providers need to expect these common events and establish procedures to deal with them. For instance, family planning programs can create back-up plans to deal with crises in service delivery, such as stock-outs in contraceptive supplies. Clinics can borrow supplies from another service delivery point or place emergency orders with a local pharmacy. In Moldova two district health centers swapped supplies to avoid wasting contraceptives whose labeled expiration date was approaching (52). Even when programs have strong supply chains, mechanisms for coping with stock-outs can assure continuity.

Organizations also must cope with both temporary and permanent loss of staff members. In such situations workloads can be reorganized and specific tasks reassigned to other personnel to deliver uninterrupted care. One way to ensure that other health personnel can fill in when a primary service provider is unavailable is to train teams, rather than individuals—part of an approach known as whole-site training (14). The people trained can then become responsible for sharing their knowledge and skills and for training others. Also, developing plans for hiring back-up personnel quickly can ease shortages.

3 Seek help in making changes. Organizations should ask clients and other key program constituents—that is, stakeholders—for their opinions and suggestions about how to make changes (61). A variety of stakeholders can help, including board members, community leaders, partner organizations, policy-makers, and donors.

Clients and other stakeholders can generate ideas and build consensus about changes, increasing acceptance and reducing resistance (72). Stakeholders are more likely to be committed to new program activities if they are consulted in the beginning and involved throughout the planning process. By providing advice and expressing their interests, stakeholders can claim ownership of and investment in improved services.

Clients and other stakeholders can provide feedback, both individually and from the community, through such techniques as exit interviews, follow-up interviews, focus-group discussions, suggestion boxes, and community meetings (55, 96, 122) (see box, at left). Community participation empowers community members to solve problems and ensures that clients' needs determine improvements (29, 65).

3 Links with Other Services and Sites

Good referral systems help family planning and other clinics offer clients the right care in the right place. Linking services with delivery sites offers clients access to appropriate care at every level of the health care system—from community facilities for basic care to district, regional, or higher-level facilities for specialized care.

costs. For instance, syndromic management of vaginal discharge has been shown to be ineffective for identifying cervical infections such as gonorrhea and chlamydia (24, 106). Syndromic management can, however, still successfully distinguish genital ulcers and, in men, causes of urethral discharge (27, 85, 120).

3 Remove unnecessary barriers that hinder access to care. Unnecessary medical barriers, such as examinations, standards, eligibility criteria, or practices that have no scientifically demonstrable value, can deny people access to services (8, 21, 54, 82, 104, 108, 110). They can also increase clients' costs, waste their time, and restrict their options—for example, by needlessly limiting their choice of contraceptive methods (10).

Unnecessary barriers arise for many reasons. Service delivery guidelines that shape provider practices may be outdated. Providers may misinterpret or ignore service delivery guidelines and instead impose barriers of their own. For example, providers may impose barriers based on gender or race or impose inappropriate contraindications to use of a method such as a woman's young age or low number of children she has (126).

A common unnecessarily restrictive practice is denying a woman access to hormonal contraceptives or the IUD if she is not menstruating (16, 76, 104, 108, 109). Providers want to be sure a woman is not already pregnant when she starts the method. Providers may not know that they can ask other questions to make reasonably sure that a woman is not pregnant. A simple checklist can reduce this common barrier (109) (see diagram, at right).

In Kenya a study to test the effectiveness of the checklist found that it ruled out pregnancy for 88% of 1,800 new, nonmenstruating family planning clients. Comparing the results of the checklist with results from a commercial dipstick pregnancy test, the study found a 99% probability that a woman identified as not pregnant by the checklist is actually not pregnant (35, 109).

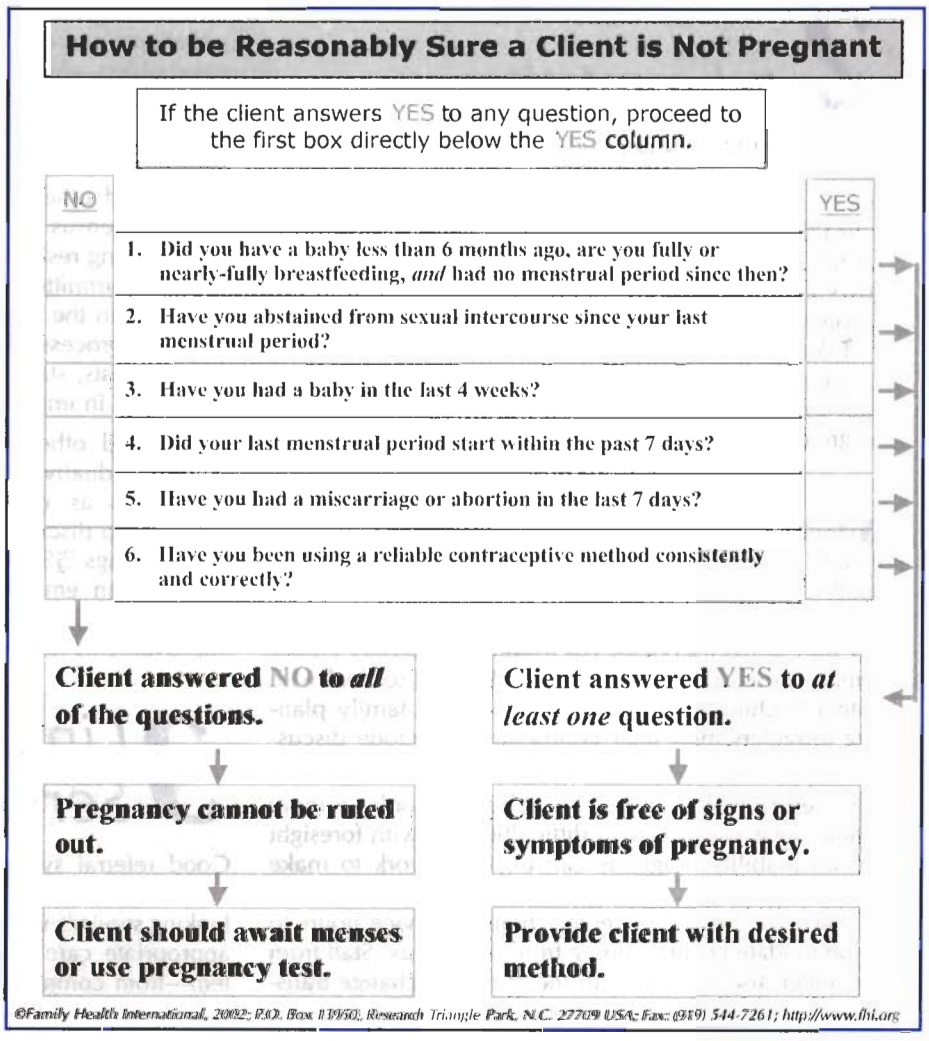
Often, providers deny some women access to family planning because they want to protect clients from contraceptive methods that they believe, incorrectly, cause infertility or other health problems (6). Others may be biased against specific methods because of their own experience as a user, the experiences of a few of their own or colleagues' clients, or circulating rumors. When organizations correct misconceptions and demonstrate in practical terms how incorrect beliefs can limit clients' choices, providers may be able to overcome such barriers (see box, at top right of this page).

Principles in Action

Kenya: Removing Unnecessary Barriers

In 1993 health personnel at the Family Planning Association of Kenya (FPAK) reviewed clinic practices and procedures during an assessment of the quality of care. They found that some protocols were denying women services unnecessarily. For example, one protocol required married women to obtain consent from their spouses before being able to receive tubal ligation, even though neither Kenyan law nor international standards for medical care call for such a requirement.

After discussions that centered on women's rights as individuals as well as on medical procedure, clinic staff agreed that spousal consent was desirable but should not be required. The staff also changed other clinic rules that often restricted services to unmarried women. Such changes in clinic practices reflected changes for the better in providers' personal attitudes toward clients. "Just as we as providers are being trusted to make decisions, we have to trust our clients, too, and believe that they will do what is right for them," said one staff member (13).



Referral systems can give clients access to a complete range of services without interruption or unnecessary repetition of diagnosis or treatment. They also enable health systems to offer services in a central location that are not in enough demand to offer at every clinic.

Principles for Linking with Other Services and Sites

1 Strengthen links between services. Referral agreements between health care facilities give clients better and quicker access to specialized services and follow-up care. Every facility at every level of the health system should be able to provide appropriate referrals. For instance, community health centers should be able to refer clients to district and regional facilities, government facilities should be able to refer clients to nongovernmental and other local clinics, and so forth.

Referral systems are vital because not all services can, or should, be offered at all facilities (see box, at right). For instance, not all service delivery sites have the equipment and trained providers necessary to insert IUDs and implants, or to perform sterilization procedures.

For certain types of services, such as urgent care for obstetric complications, the health system's ability to arrange transport is a crucial part of its service delivery links. Facilities can work in advance with community organizations or unions to provide emergency transport in the event of obstetric complications (87). In the Kolokani region of Mali, for instance, contributions from the community and individual patients support a transportation and referral system for women who need emergency care during labor and delivery (7).

Organizations need to ensure that staff understand the value of referral and are familiar with referral procedures. Lists of contact names for services and referral sites, as well as information on hours of operation and fees, often make it easier for staff to refer clients.

2 Use both internal and external sources of referrals. Programs can establish procedures to make better use of internal referrals (that is, referrals within the same facility), as well as referrals between facilities. A facility that provides multiple services can coordinate services and scheduling procedures among its departments. Then, when clients come to see one provider, they can also schedule appointments with other providers in the facility or even receive referral services on the same day.

Facilities also can provide related services together, so that clients do not have to make repeated visits or wait more than once to see different providers. For instance, in the mid-1990s a Tanzanian hospital began offering family planning to women who brought sick children for care or who were giving birth in the hospital. Previously, contraceptives were not being offered directly through the maternity ward. Women had to make a separate visit for family planning services (31) (also see box, page 8).

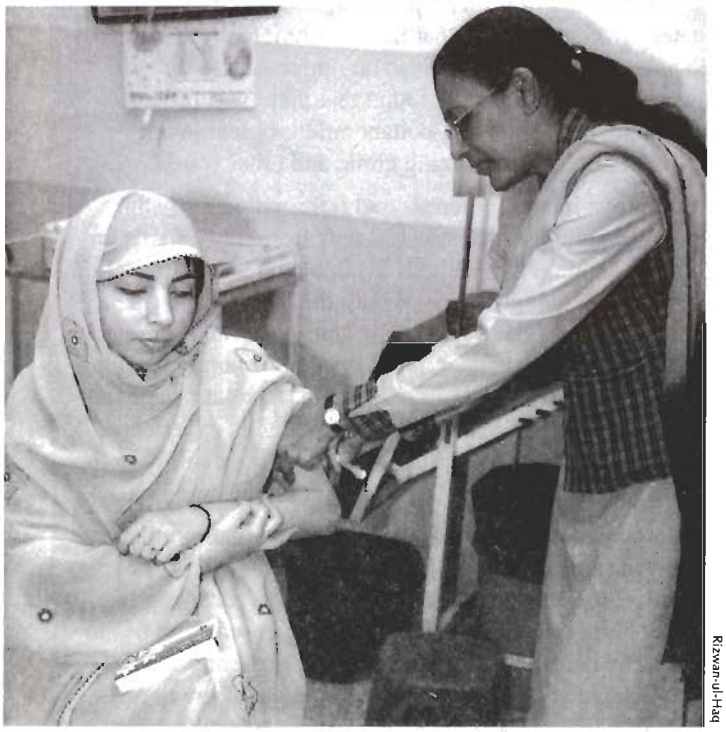
3 Deliver each service at the lowest-level facility that is practical. Programs can provide services at convenient locations throughout the community to minimize

Principles in Action

Pakistan: Establishing a Client-Oriented Referral System

Since 1995 family planning and other reproductive health services in Pakistan have been linked nationwide through a network of more than 12,000 private doctors, pharmacists, and "lady health visitors"—female staff who run small clinics or make house calls—as part of the national ***greenstar*** Program. The network includes the ***greenstar*** Program's own clinics, those of its nongovernmental partners, and other health facilities. Each year, the network clinics serve several million women, particularly low-income women. Services provided include family planning, nutritional supplements, management of reproductive tract infections and STIs, and antenatal and postnatal care.

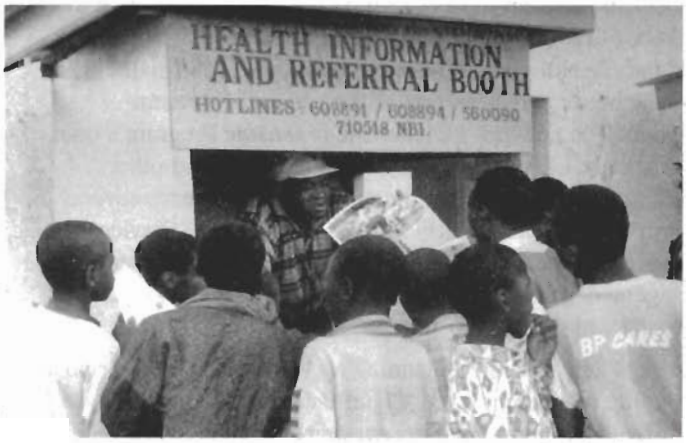
Providers deliver family planning services based on their position in the referral network. Clients seeking services that are not offered by a particular ***greenstar*** provider are referred to other providers within the network. For instance, ***greenstar*** female providers and male doctors refer clients seeking surgical contraception or other special services to ***greenstar*** Plus clinics. Similarly, lady health visitors and chemists, who provide only nonclinical contraceptive methods such as condoms and oral contraceptives, may refer clients to ***greenstar*** female practitioners for IUD services. Thus the ***greenstar*** network clients have access to the broadest possible range of health services. Record-keeping mechanisms, referral cards, group meetings, training, and refresher courses help providers in the network coordinate and communicate (3, 43).



Rizwan-ul-Haq

In Karachi a nurse gives a contraceptive injection. Programs that have referral networks help ensure that clients have access to a range of services at appropriate levels of the health care system.

the distance clients must go to see providers. For instance, door-to-door distribution of condoms and other supply contraceptives can reduce time and costs for clients. Community approaches often are the only way to reach women who cannot leave home (22, 23). They are also useful in rural areas not populous enough for a health post.



IHU/CCP

Young men in Nairobi visit a health information booth during a football tournament. Programs can reach more people by providing services in the community, including door-to-door.

Principles in Action

Kenya: Improving Internal Links

In the early 1990s the Kenyan Ministry of Health (MOH), together with the Christian Health Association of Kenya (CHAK), carried out a plan to improve links between units and departments within a CHAK hospital. The plan developed after interviews with prenatal, child-welfare, and maternity clients found that many were interested in family planning but few had received any information about it. Interviews with staff then found that there was little exchange of information, collaboration, or teamwork between the family planning clinic and other wards.

To improve internal referrals and information exchange, family planning staff instructed staff from other wards on family planning, the methods available on site, the location of family planning services within the facility, and the clinic's hours of operation. Also, staff from the different departments agreed on a referral system for family planning within the hospital and discussed plans to rotate ward staff through the family planning clinic. With this experience, these staff could offer certain contraceptives directly in the wards and better identify potential family planning clients.

Follow-up surveys six months later found that more clients received family planning information in the wards. For instance, the percentage of prenatal clients receiving individual family planning services had increased from 6% to 29%. The percentage of women in the maternity wards who obtained family planning information at group talks increased from 20% to 65%, while the percentage who received a contraceptive method before discharge from the hospital increased from 2% to 15% (69).

Where programs do not provide services in the home, they can provide community education and referral. In Botswana, for example, the public's most frequent point of first contact for family planning is a family welfare educator. The educator is not authorized to offer clinical services or to supply contraceptives but instead provides health education, counsels clients about family planning options, and makes referrals to family planning clinics (8).

Programs can promote partnerships between the communities they serve and the health system. In Ghana the Ministry of Health and the Ghana Health Service joined with local traditional care systems. One of the projects improved referral and transport of women needing emergency obstetric care. Traditional birth attendants (TBAs) were linked with physicians at health centers by two-way radio. A motorized three-wheel vehicle was adapted to transport the women. Using this system, the TBAs were able to refer over 1,000 women for emergency obstetric care in 1996, a three-fold increase from 342 women in 1995 (51, 83).

4 Minimizing Paperwork, Maximizing Information Use

At every level of a health program, collecting up-to-date, reliable, and relevant information is crucial to analyzing operations, solving problems, identifying trends, setting goals, and using resources wisely. Managers can encourage their staff to collect and use only essential data. Collecting too much data can waste time, produce unnecessary paperwork, and obscure rather than illuminate decision-making.

Principles of Information Management

1 Collect what is needed, but no more. The information that managers and providers collect should relate directly to the decisions that they must make. For instance, supply managers need only data from their own organization—such as amounts currently in stock, rates of consumption, order dates and receipts, and amounts ordered—to know when to order more supplies (36, 115).

District or provincial program managers need more than just local data. For example, having both national and local data on the number of postpartum women receiving family planning services can help managers compare their program's output with that of other programs and possibly identify where improvements can be made (99).

Collecting only essential data reduces paperwork. Managers and providers can decide what data to collect by looking at organizational objectives and selecting indicators that measure achievement of them (73). For instance, before 1997 in the Eastern Cape district in South Africa, health facilities collected and sent vast amounts of data up the information pipeline. Much of the information collected was unnecessary, and the few useful data were lost in the mass of numbers. The clinic and hospital managers determined which information was essential for their facilities to function effectively and selected appropriate measurable indicators. The value of the data

to the facilities increased, while the volume of data reported up the information pipeline decreased (33).

❷Make good use of what you collect. Managers should be able both to analyze the data that they collect and to act on it. Once collected, the data should be tabulated and summarized in reports that facilitate access and analysis. To be useful, data must be converted into information that can be easily understood and delivered to the program staff who are able to apply it in decision-making (see box, at right). Too often, however, managers simply aggregate the data and report them to higher levels.

Developing a plan for sharing information is important to get the right data to the right people in a useful form. As a first step, creating an information flow table that summarizes how information moves internally can help managers discover which staff need what information, how they will use it, and how detailed the information needs to be. This flow table will help staff compare current with desirable practice and close the gaps (123).

❸Empower staff to both collect and use data. The more relevant that data are to program staff members' jobs, the more that staff are likely to collect data accurately and on time (66). When they understand how program data can be used to identify problems or improve services, staff are more likely to make use of data (15). Charts and diagrams can help. For example, in maternal and child health and family planning centers in Istanbul, Turkey, the staff recognized that recording on a central wall chart the number of family planning clients as well as stock levels of IUDs, pills, and condoms improved their ability to monitor supplies and avoid shortfalls (32).

❹Provide feedback on data collected. Managers can show providers the importance of data by providing feedback on the data collected and used. Feedback also displays appreciation for staff effort and motivates staff to maintain the information system regularly. To provide constructive feedback, managers should determine whether data are being provided on all key indicators, all gaps in data collection have been identified, information is accurate and reliable, and decisions or actions are based on the data (123). If staff members are making many mistakes in collecting, tabulating, or analyzing data, managers may need to redesign or simplify clinic forms or to train staff to reduce errors (115).

Facility

5 Physical Factors

The physical factors that need to be managed for better organization of work include both the supplies and equipment needed to provide care and the facility space in which people work. Health care staff can make the best of resources at hand when they are resourceful. Both providers' and clients' convenience should guide the use of available clinic space.

Principles of Physical Factors

❶Encourage staff to be resourceful about supplies and equipment. Worldwide, virtually every health care organization faces resource shortages, whether in funding, equipment, medical supplies, or other items needed to deliver care. Resourceful organizations do not let such constraints prevent them from doing the best they can. Resourcefulness means finding creative ways to solve problems with the resources at hand. For example, when beds were in short supply at a hospital in Tanzania, staff repaired damaged beds by welding locally available wire mesh to bed frames (30). In Mongolia during a severe winter, hospital staff sealed the windows to keep out the cold, sewed hats for newborns, and appealed to a local company to donate warm clothes and blankets (52).

Water and electricity are often in short supply. Clinics can instead collect rainwater and can use gas or firewood for heating or use solar power systems where feasible for heating and refrigeration (8, 74, 80). At a rural health center in Cambodia, the local water pump was broken. The clinic could obtain water from a nearby well and from a rainwater storage tank. But the well water was muddy, and the storage tank had no cover, allowing dust and mosquitoes to contaminate the water. To assure safe water, community members built a wooden cover for the storage tank, while the clinic made plans to dig a new well (92).

Ensuring adequate stocks of contraceptives, medicines, and other essential supplies is even more important (53, 97). To keep supplies continuously in stock, clinics need good supply management strategies (101) (see top box, page 10). Setting up emergency procedures can help (see p. 6). Also, staff members who are responsible for estimating and obtaining supplies need to communicate with front-line providers, who best know their clients' needs, in order to obtain products that clients are likely to want.

Principles in Action

India: Using Data Effectively

In India health workers at a rural hospital in Bhorugram, Rajasthan, used data on immunization dropout rates to improve childhood immunization coverage dramatically. In the early 1990s the hospital installed a computerized system to collect and manage client data. With access to the new system, service providers discovered that fewer than half of children in the area received full immunization coverage against the six major childhood diseases. The 1990 World Summit for Children had set a goal of immunizing 90% of children under one year of age by 2000 (117).

Alerted to the wide gap between actual and recommended immunization rates, the dispensary staff began an outreach campaign. The hospital's community health workers and auxiliary nurse-midwives visited the 40 surrounding villages and urged parents to have their children immunized.

The number of child immunizations increased dramatically. In 1996, for example, 82% of children in the community were fully immunized, compared with just 45% in 1992, before the campaign began. Encouraged by this success, clinic administrators are using the outreach workers to promote other primary health care services, such as antenatal care and family planning (105).

2 Tailor clinic space to clients' and providers' convenience. Clients prefer clinics that are clean, organized, and comfortable (96). Often, simple, inexpensive solutions to problems can make the clinic setting friendlier to clients. Efforts to make visiting clinics more convenient for clients and to arrange waiting areas that reflect gender and cultural norms help clients feel comfortable. For example, a children's corner and activities can keep children occupied while their mothers receive care. Where husbands accompany their wives but by custom cannot enter the clinic itself, a separate waiting area and educational materials can encourage couples to visit the clinic (52).

Redesigning the work space can ensure more privacy for clients through such changes as repositioning the examining table so that clients' feet do not face the door, using screens and curtains, and minimizing traffic around examining areas. Moving door hinges so that examining room doors swing outward also can increase privacy (12).

Rearranging clinic space can help staff work more easily. For instance, the proximity of staff members' work areas can affect the ease and time it takes to perform procedures. Moving the steps in a process closer to each other helps staff pass work directly from one step to the next, improving efficiency (94) (see box, at bottom left).

Principles in Action

Turkey: "Topping Up" Contraceptive Supplies

In 1996 the Maternal and Child Health/Family Planning Directorate of the Turkish Ministry of Health adopted a plan to improve contraceptive availability. They developed a contraceptive distribution system known as "Top-up" to regularly replenish IUDs, oral contraceptives, and condoms throughout 22 high-priority provinces in the country.

In this system specially trained distribution officers visit each clinic in the 22 provinces at four-month intervals. At each clinic the distribution officer counts the number of supplies on hand, calculates the average monthly consumption for the previous four months, uses this number to estimate needs for the next four months, and "tops up" the supplies to this amount. The officer also inspects the clinic's storage facility and suggests ways to correct problems.

A 2000 evaluation of the system found many benefits. Damaged and expired stock had been identified and removed, and storage conditions had improved. Contraceptive stockouts had been reduced substantially and in some cases eliminated entirely. Distribution of contraceptives to clients had increased greatly, too (116).

Principles in Action

Brazil: Organizing Space to Improve Services

In 1996 the director of the health unit in Camaçari, Brazil, reorganized the clinic to place related services nearer together. Previously, services were organized haphazardly across the four wings of the clinic, which was shaped like a capital "H." The unit was redesigned to make each of the four wings into a separate service area—childcare, adult care, women's services, and administration, where offices, meeting rooms, a kitchen, and dining area for staff were created.

The reorganization reduced client and provider traffic, improved infection prevention, and made working at the clinic more pleasant and productive. For example, the sterilization room was moved to the end of the administration wing so that fewer people passed through or near it. This change reduced the risk of passers-by contaminating sterilized equipment. Access to the pharmacy was changed to an outdoor entrance only. This change eliminated the congestion caused by people waiting inside the building for medicines or contraceptives (95).

6 Service Hours and Scheduling

Health care organizations should consider both clients' and providers' needs when setting schedules for service delivery. Clients can obtain services more easily when offered convenient hours, flexible scheduling, and follow-up that ensures continuity of care (17). Providers can do their work better when given sufficient time during the day to perform responsibilities other than seeing clients—such as completing paperwork—and when given adequate breaks.

Principles for Tailoring Service Hours and Scheduling

1 Base service hours and scheduling on both clients' and providers' needs. Both clients and providers benefit when service hours and scheduling take their needs into consideration. Clinic hours can inadvertently limit clients' access (48, 78, 100). For instance, male clients can be discouraged by daytime clinic hours that conflict with their work schedules and thus force them to choose between seeking care and losing a day's wages (119).

Clients have better access to health services when clinics announce their hours of operation and adhere to them (75). Clients also want adequate time to talk with providers. They are more satisfied and more likely to return for follow-up care when they get that time (5, 56). With adequate time, providers can encourage clients' questions and ensure that clients understand instructions (59, 118).

Accounting for providers' situations is as important as scheduling to meet clients' needs. Providers may not be able to see clients during certain times of the day because they must do paperwork, or they necessarily spend less time with each client because their caseloads are too heavy (66, 67, 86). Providers may have to delay seeing clients in the morning because they are preparing for the day's work. In such cases clinics can change their procedures—for example, scheduling service preparation activities before the clinic officially opens its doors to clients or after it closes (75).

2 Convey guidelines for follow-up clearly. Clinics should have an organized system in place to help clients

return to the clinic as needed (see box, at right). Family planning providers can explain routine reasons for return, such as contraceptive resupply or a next injection, and discuss how often the client should come back. Providers also need to ensure that follow-up is appropriate to the contraceptive method and that excessive follow-up requirements do not discourage continued use. For instance, providers can give women up to a year's supply of oral contraceptives. They do not need to return to the clinic sooner unless they have problems (125).

Telling clients when and where to return for a visit makes it clear whether follow-up care is necessary—a point that many clients may otherwise not know. Providers need to distinguish between routine care and emergency care and to explain separately the reasons to see a doctor or nurse immediately, such as signs of possible complications associated with the client's family planning method (46). Studies find that many providers discuss the return visit and track when clients return, but that others do not do so consistently (6, 58, 75, 112).

Scheduling appointments in advance encourages clients to return for follow-up visits. Programs with community-based links can maintain relationships with clients through health workers' home visits, rather than requiring trips to a clinic (113). Even follow-up after female sterilization or vasectomy can be handled in a home visit (46).

3 Make gate-keeping appropriate to the need. The provider's role as gatekeeper often affects how and when clients receive services and even whether clients receive services at all (103). Providers are gatekeepers in the sense that they manage the client's treatment plan. They have the authority to decide on a course of care and either to provide care themselves or to refer clients elsewhere. Providers must ensure that in their role as gatekeepers they do not impose unnecessary medical barriers to care (see page 5). Since clients know their own needs for such services as family planning, client preferences, not provider preferences, should guide health care decisions to the extent possible (118).

Service providers are not the only gatekeepers at a clinic. Receptionists, clinic guards, and anyone else who affects clients' access to services are gatekeepers. Clinic guards, for example, can prevent some people seeking care from entering the clinic, while receptionists can control the order in which clients are seen. Managers can ensure that these gatekeepers make it as easy as possible for clients to obtain services. They can inform staff about the location and hours of all services offered, establish and display client check-in procedures, and require that guards keep the clinic open to all during clinic hours.

7 Client Flow

Improving client flow—how clients move through a clinic—can avoid bottlenecks that cause delays and reduce the quality of care. Often, poor client flow causes long waits that discourage clients from seeking services (26, 122). Clinics can improve client flow through better planning and resource allocation.

Principles in Action

Senegal: Improving Continuity of Care

In 1998 and 1999 Senegal's family planning organization Association Sénégalaise de Bien-Être Familial (ASBEF) conducted a quality improvement exercise at a clinic in the coastal town of St. Louis. Analyzing service statistics, the quality team found that many clients were not returning for their follow-up visits.

In response, clinic staff devised a strategy. The clinic established a way, through its filing system, to track clients who did not return for follow-up appointments. Community outreach workers visited these clients at home to find out why they had not returned to the clinic. The outreach workers also explained the importance of follow-up and encouraged clients to revisit the clinic. At the same time, providers in the clinic began to emphasize follow-up during counseling sessions. They told clients specifically when and where their next visit was scheduled. Providers scheduled the next visit to coincide with the clients' needs for contraceptive resupply. As a result, the number of clients who returned for services increased steadily—from fewer than 100 clients per month before the strategy was put into effect in 1998 to over 400 per month in May 1999 after implementation (37, 81).

Principles of Client Flow

1 Balance client load and client flow. Improving client flow can help shorten the time that clients spend waiting, increase the number of clients that a provider sees each day, or allow providers to spend more time with each client (52) (see box, page 12). Clients are more satisfied with services when they spend less time waiting and spend more time with the provider (96).

JHU/CCP

In a Nigerian family planning clinic a health care worker discusses contraceptive methods with clients while they wait their turn for individual counseling. Shortening waiting time and making better use of it can improve clients' satisfaction.

Client flow analysis can help. Client flow analysis involves recording a sampling of clients' arrival times and lengths of time spent in contact with staff members (70). By summarizing and graphing these data, managers can calculate how much time clients spend waiting compared with seeing providers, and where the greatest delays occur.

Causes of long waits vary; so do their solutions. If providers face a backlog of clients at some times but see fewer clients during other parts of the day, changing when clients are scheduled can shorten waits (5, 50, 121). If providers need to fit walk-in clients among scheduled clients, the clinic can encourage more scheduled visits in advance or can allow more time between scheduled appointments (52).

Sometimes, check-in procedures have not been established at all. Giving clients numbered cards when they arrive and calling them by number can shorten waits and increase client satisfaction with services, as in a clinic in Cambodia (91). Also, showing videos or providing educational pamphlets in the reception area can keep clients engaged while they wait.

2 Improve client flow by using signs, posted instructions, and simplified paths. Organizations can improve workflow and direct clients through clinics by putting up signs and graphics. Signs that convey clinic policy can tell clients when they can expect to be seen by a service provider. For example, walk-in clients who are waiting may observe that other clients who came in after them are seen first, leaving them wondering why they must wait. In this case, displaying signs explaining that clients with appointments are seen first, and then walk-ins, can reassure them (12).

Often, organizations can improve workflow by reducing the number of steps required to deliver a particular service, shortening the time clients must wait between steps, and eliminating procedural bottlenecks. For instance, in 1999 in Jordan, hospital staff divided the emergency department into three parts. First, patients were examined in a pre-screening area. Then they were moved to a newly designated triage section to determine who needed care immediately and who could be referred to the outpatient department. These changes helped to streamline service delivery, keep patients moving from one step to the next, and reduce waiting lines (107). Family planning facilities can create express lines for clients obtaining repeat injectable contraception, so that clients returning to the clinic to receive routine injections, if they have no problems, do not have to wait with clients receiving more time-consuming services.

Principles in Action

Malawi: Meeting Both Clients' and Providers' Needs

In 1996 staff at a district hospital in Malawi performed a client flow analysis to assess waiting time. They found that clients waited an average of over two hours for services but spent only an average of two minutes in direct contact with a provider. The long waits resulted from the practice of giving a group health education talk to clients first. Providers saw clients individually only after the group health talk. Therefore many clients had to wait while others saw providers. Since the clinic waited until a certain number of clients had arrived before giving the talk, providers had a window of open time and then had to rush through counseling sessions to accommodate the backlog.

To overcome this problem, the clinic eliminated the group health talk. Providers saw clients individually as soon as they arrived, providing the same information given previously at the group talk. This change enabled providers to spend an average of 10 minutes with each client, taking time to answer questions and address the health issues of greatest interest and relevance to each client. Waiting times decreased by two-thirds for family planning clients and by more than three-quarters for antenatal care clients. The change also helped relieve the pressure on providers (40, 66).

Gary Bergthold/JHPIEGO

In Indonesia family planning providers practice Norplant implant insertion techniques with the use of a training arm. One principle of effective organization of work is to delegate responsibility—training nurses to insert implants, for example.

Personnel

8 Division of Labor and Job Design

Health care workers do a better job and are more satisfied with their work when they know what they are expected to do and have the authority to do it. Also, staff members can be more effective and the organization can accomplish its objectives better when the organizational culture and managerial structure promote teamwork and focus on serving clients.

Principles of Division of Labor and Job Design

1 As appropriate, delegate responsibility to the lowest-level front-line provider. With suitable training, nurses and midwives can perform many procedures, such as inserting implants or IUDs (2, 34, 38, 98). Regulations or

policies that restrict such practices to physicians can limit clients' access to these services. Training and authorizing nurses and midwives to insert IUDs or counsel for sterilization can be a straightforward way to increase access to services (see top box, at right).

2 Align authority with responsibility. Many health staff believe that they are responsible for performing duties but have little authority to make decisions or to solve problems that could help them do their jobs better (41, 68). When staff members are empowered to make the decisions that their jobs require, they can better solve everyday problems themselves, rather than needing to seek guidance or permission from supervisors (30, 31, 52). At a district health center in Dar es Salaam, Tanzania, clients felt embarrassed seeking treatment for sexually transmitted infections (STIs). Employing her authority, the clinician in charge decided to eliminate the requirement that STI clients first meet with the admitting provider. Instead, clients could go directly to the office that offered STI-related services. This change increased confidentiality and reduced the likelihood that clients would find the experience uncomfortable and thus avoid seeking services (114).

Empowered providers are more committed to their work and feel more control over it, rather than seeing themselves as just following instructions or orders (39). To enable staff to make decisions and take action, managers can clarify responsibilities through written job descriptions, let staff know that management expects and appreciates initiative and participation, and provide training and supervision to build decision-making skills.

3 Relate job responsibilities to the goals of the organization. Managers can clearly define and document staff members' responsibilities, explain the organization's mission to them, and involve them in interpreting what this mission means to their own work (84). When supervisors and providers work together to define responsibilities, providers are more likely to understand what is expected of them and to act accordingly.

Where formal job descriptions are unavailable, the organization's mission statement or an institutional motto or slogan can provide temporary or complementary solutions to help staff members understand how they are expected to perform (4, 39). A study in Kenya found that providers and supervisors in high-performing health care facilities typically knew the organization's mottoes, such as "serve our clients and they go home happy," "do it yourself," and "good to be part of a family." These slogans encouraged staff to be sensitive to clients' needs, fostered self-initiative, and provided general performance expectations, even in the absence of written job descriptions or well-defined roles (90).

4 Promote teamwork and avoid hierarchical thinking. Often organizations have too many layers in a hierarchical structure, too little coordination, or poor internal communication. This structure can block good performance.

In particular, hierarchical organizations tend to promote only vertical flows of information, typically downward from top managers through supervisors to service providers and other subordinates. Vertical communication can ensure that roles and reporting relationships are well-defined (77). But also sharing information and coordinating activities horizontally—that is, among workers at the same level in different units—can help promote teamwork and problem-solving (111).

For instance, people from different departments who do different jobs can work together in cross-functional teams (25, 59). By bringing together all the people involved in a process, horizontal teams often can assemble a more complete picture of what to do than can a purely vertical hierarchical organization. Also, teams can examine the entire system for weaknesses and recommend better solutions (see box below, at bottom).

Principles in Action

Indonesia: Nurses and Midwives Successfully Provide Implants

In the early to mid-1980s the Raden Saleh Clinic in Jakarta, Indonesia, trained nurses and midwives to provide *Norplant* implants. Participants learned to counsel and educate clients on the use of implants and to insert, manage, and remove the implants.

During the first six months of a two-year field trial beginning in 1982, nurses and midwives, instead of physicians, performed 543 of the 828 implant insertions and 79 of the 122 removals. The time for nurses and midwives to insert or remove the implants (7.4 minutes for insertion and 21.8 minutes for removal) was virtually the same as for physicians (7.6 minutes for insertion and 21.7 minutes for removal). There was no significant difference between the nurses and midwives and the physicians in frequency of complications during or following insertion. The study concluded that nurses and midwives can be as qualified as physicians to insert and remove *Norplant* implants (2).

Principles in Action

Costa Rica: Solving Problems with Cross-Functional Teams

In the mid-1990s in Costa Rica, the staff of local health facilities, with the Caja Costarricense del Seguro Social (the Social Security Bureau of Costa Rica), worked together to improve quality of care. At one clinic nurses and physicians from the outpatient department met with clerical staff from the medical record filing office to find ways to reduce the time needed to retrieve patients' medical records. Partly because the team had a full view of the records-handling processes, they quickly analyzed the problem and easily found a solution. The team developed a new filing system for records and a new process in which clients' records would be available to physicians the day before clients' appointments. This team approach shortened retrieval time for medical records from 70 minutes to 24 minutes (42).

H. Kakande/DISH II Project

At a Ugandan family planning facility, staff members discuss responsibilities. Leaders play a key role in encouraging and enabling staff to take responsibility for improving services.

Principles in Action

Uganda: Improving Supervision

In 2001 and 2002 the Uganda Family Life Education Program (FLEP) sought to improve supervision and performance appraisal at FLEP clinics in the Busoga region. These efforts were part of a larger project to improve human resources management.

FLEP first encouraged supervisors and providers to communicate more often and reviewed and updated staff salaries. Next, FLEP updated its personnel policy and procedures manual and distributed it to management and supervisory staff in its 49 health facilities. Job descriptions and personnel files also were updated to provide staff with clear performance expectations.

FLEP also addressed the supervision process. Clinic supervisors were given a day's training on how to use a newly developed performance appraisal checklist, communicate better with employees, and provide feedback.

Approximately eight months later, in an evaluation, the staff reported increased satisfaction with many supervisory practices. For instance, staff responses to the statements, "I get clear feedback from my supervisor about how well I am performing my job" and "My supervisor applies personnel policy and practice fairly to me" improved to an average score of four on a scale of one to five, compared with a score of just one beforehand (84).

9 Social Factors

People are a health care organization's most valuable resource. When providers are motivated and perceive that their work benefits clients, they can deliver better services (49). When managers enable their staff to obtain and maintain the skills and support that they need to be productive, they also help to meet clients' needs (63).

Principles of Social Factors

1 Provide leadership and motivation. Leadership is vital to performance. Leaders inspire people through their own positive behavior, ethics, and values and thus serve as role models. Their shared vision provides staff with purpose and direction in their work.

Managers who are leaders motivate staff and encourage them to take responsibility for solving problems and improving services. They improve morale and performance by giving encouraging feedback and helping staff to see how their jobs benefit clients and enable the organization to achieve its goals. They also organize people to work together collaboratively and effectively.

To perform well, staff members need to know how they are doing compared with expectations for their job. Managers can clarify what is expected by preparing and distributing guidelines and by writing job descriptions and discussing them with staff (11, 47, 62) (see box, at left). Feedback on job performance can come not only from supervisors' evaluations but also from clients' comments and from self- and peer-assessments (9, 71).

2 Develop staff potential. Program staff are more satisfied and perform better when they know that the organization is committed to their personal and professional development (84). The organization can encourage staff to improve their skills and their performance continually through training and job aids (57). Skills training can even empower staff to make decisions without the need for guidance from supervisors (13, 31). Managers also can provide rewards and recognition for good performance (62).

3 Enable positive human relationships. Health care providers need to be able to interact and communicate well with their clients, as well as with their supervisors and co-workers. When clients and providers communicate openly, share information, and ask and answer questions freely, clients are more satisfied and understand and recall information better (28, 56, 118). Staff members who are able to communicate openly with their supervisors and co-workers can do their jobs better (49, 71).

Promoting amicable and constructive staff relationships is vital to teamwork and other problem-solving approaches. In a health center in Brazil, for instance, the entire staff was encouraged to participate in an effort to improve infection prevention—not just the professional staff but also the support staff, including the janitor. In fact, it was the janitor who told managers that the water cistern serving the clinic had never been cleaned and thus posed a health threat (64).

Implementing the Concept

What can health care managers and providers do to apply the principles of organization of work to their own organization? Assembling a group of people from different parts and levels of the organization, both front-line staff and higher-level management, can make a good starting point. The group can take a step back from day-to-day activities and look at how work is designed and performed within each of the nine elements in this report. Reviewing the steps in current processes can reveal which processes are working well and which are not. Choosing the organization of work principles that fit the situation can help staff devise better ways to work (see box, below).

Often, however, people do not have a clear picture of work processes—especially the links between their work and the work of others. Bringing all the individuals involved in a process together enables each participant to describe his or her step in the larger process, and together to draw a basic sketch for how work flows. Visualizing the actual flow of the process and comparing it with the ideal may reveal that a step in the process is missing, that more steps exist than necessary to get a job done, that the process creates a bottleneck in care, or even that no single clear process exists. It can also reveal that certain steps confuse staff or limit clients' access to services, that tasks are not assigned efficiently, or that there are no mechanisms to reassign work when staff members are absent. When brought together, staff can also be encouraged to share personal "best practices" that could be more widely applied.

Putting Organization of Work Principles into Practice

Palestine: Reorganizing Physicians' Daily Hospital Round

The physicians and nurses at Al-Naser Hospital's Pediatric Department Two in the Gaza Strip decided to improve the morning round. Each day, the four on-duty physicians performed the morning round as a team, visiting the children who were hospital in-patients, examining them, and deciding whether to discharge them, perform further evaluation, prescribe medication, or refer them to a specialist.

The team began rounds at different times each day, and the time required to carry out each day's round varied. As the physicians made their rounds, they were interrupted by telephone calls, requests from managers, visits from patients' families, and by other physicians seeking consultation on complicated cases. The rounds were disorganized and unsystematic: Instruments and patient files often were not readily available, leaving the physicians waiting at the bedside while a nurse obtained the missing item. As a result, the physicians spent only half of the round actually seeing patients. They had little time to complete patient history forms or to write follow-up remarks in patients' charts.

To improve the morning round, a team of doctors, nurses, administrators, and other staff diagramed the steps of the morning round in a flow chart *(Principle: Promote teamwork and avoid hierarchical thinking).* After reviewing all the steps involved in the current process—that is, by looking at the "big picture"—the team agreed on a solution: divide the morning round into two parts—a primary round, beginning at 8:15 a.m., and a grand round, from 9:30 a.m. to 11:00 a.m., when hospital public visiting hours began. During the primary round each physician was assigned a number of patients to see and evaluate before 9:30 a.m., when the physicians would assemble as a group to begin the grand round *(Principles: Modify approaches as needed* and *Schedule around both clients' and providers' needs).*

As a result of these changes, the rounds began and ended on a standard schedule, physicians had enough time to write follow-up comments or to record patient histories, and the workload was distributed evenly. The team also established back-up plans in the event that fewer than four physicians could take part in the morning round *(Principle: Plan for common fluctuations in health care delivery).*

While the primary round enabled physicians to deal individually with routine cases, the grand round provided a forum for the physicians to discuss critical cases as a group and to exchange ideas for patient management and treatment *(Principle: Enable positive human relationships).* During the grand round the four physicians met with the department head to discuss the morning's cases. Usual cases were reviewed quickly, leaving more time to discuss the critical cases in detail.

In addition, interruptions were minimized. Telephone calls were answered at the nurses' reception desk, and the doctors received their messages only after rounds were done. Managerial requests that were not urgent were delayed until the end of rounds, and visitors were not allowed to visit until rounds were finished *(Principle: Make gatekeeping appropriate to the need).*

The new system provided patients with better care. Since the physicians had enough time to discuss critical cases during the grand round, they could develop more effective treatment plans. Time spent on patient-related work increased to nearly 100% from an average of 60%, and the average patient-physician contact time doubled, increasing from 7 minutes to nearly 15 *(Principle: Balance client load with client flow).* The patients' parents and other family members reported greater satisfaction with services—for example, most rated the care their children received as "excellent" on a satisfaction survey as compared with "good" or "very good" before the changes (1).

Tips for Getting Started

Whether you are a program manager, a service provider, a supervisor, or any other staff member, the following tips can help you start to improve organization of work:

1. Look at how work is now organized in your workplace. Ask yourself:
   - Why is work organized in this way?
   - Is work organized to meet clients' needs?
   - How are effectiveness and efficiency for the client balanced with effectiveness and efficiency for the staff?
   - Are all the steps and activities absolutely necessary?
   - Are there better ways to get the work done?

2. Put yourself in clients' shoes and walk through the processes that various kinds of clients experience. Consider:
   - Does the clinic feel comfortable and safe?
   - Do instructions or signs help clients find their way?
   - How long do clients wait for services?
   - Do clients know when to return for follow-up or where to go for referral services?

3. Ask clients what they think of the way service is organized. How would they suggest improving it?

4. Ask colleagues what they think of how work is organized. How would they improve it?

5. Take the responsibility to improve the way work is organized. Enlist and empower others to take responsibility also. Praise those who propose and make constructive changes to their organization of work.

6. Based on your investigations, try some different ways of organizing work that might be more efficient, especially for the client.

7. Read and share technical information on how to improve work processes (see Table 1, p. 17).

8. Over time, make more observations and ask for feedback to see which processes are working better.

9. Let other people in the organization know what worked well and what did not work well, and why.

IHU/CCP

Health providers in Mexico review program information. Improving organization of work is everyone's responsibility.

Following such a step-by-step process can help managers begin to re-think and improve the way work is organized (see box, at left). A variety of methods and tools can help managers and providers address the specific elements of organization of work discussed in this report (see Table 1, p. 17).

Managing Change

Improving how work is organized necessarily requires that people and organizations learn and change. One widely used model for managing change identifies an eight-step process that can be applied to the organization of work approach (60). These steps include:

Establish a sense of urgency. Urgency usually comes from a change outside the organization. Changes in health care service delivery—such as decentralization and integration of services—and the HIV/AIDS epidemic are among the many challenges facing health care organizations. The organization of work approach points to ways organizations can find new ways to perform familiar tasks better, to reduce waste, and to operate more effectively.

Form a powerful guiding coalition. Staff members and other stakeholders need to participate in the process of change. They know the work and its processes better than anyone else. Thus they may have the most practical ideas about how to improve their work, what changes can work, and what could go wrong.

Create vision. Creating a vision for change enables the people most affected to appreciate the need for it and how it benefits them. People are most likely to accept change that has a compelling reason or an obvious direct benefit.

Communicate the vision. Through their words and example, leaders can motivate and persuade staff to adopt and maintain new and better ways of working. Leaders must emphasize the vision repeatedly in order to make it everyone's guiding principle.

Empower others to act on the vision. Managers need to inspire and empower staff to change the way they think about and do their work. Managers can express their appreciation to staff who act on the vision and who make constructive changes.

Plan for and create short-term wins. Change often takes time. Thus setting up and meeting shorter-term goals, or "wins," can help staff stay motivated. Recognizing and rewarding people who help achieve these goals can help keep staff on track for the longer term.

Consolidate improvements and produce still more change. Managers must obtain feedback from staff to see which processes are working better and where improvements are still needed. They must let people know what worked well and what did not work well in order to continue making improvements.

Institutionalize new approaches. Finally, for change to be successful and lasting, the new ways of working should become a part of the norms and values of the organization. When health care providers commit themselves to improving the organization of work, they can offer better services and have more satisfying jobs.

Table. 1 Improving Work Processes: Methods and Tools That Can Help

Methods and Tools	Use of Evidence-Based Practices	Adaptability	Links with Other Services and Sites	Minimizing Paperwork, Maximizing Information Use	Physical Factors	Service Hours and Scheduling	Client Flow	Division of Labor and Job Design	Social Factors
Client-Oriented, Provider-Efficient (COPE)[a] http://www.engenderhealth.org/pubs/pubslist.html#quality		X	X		X	X	X	X	
Community COPE[a] http://www.engenderhealth.org/pubs/pubslist.html#quality	X	X	X		X	X	X	X	X
Concepts of Logistic System Design[b] http://deliver.jsi.com/pdf/G&H/logistics_system_design2.pdf				X	X			X	
Developing National Training Strategies in Family Planning Logistics[b] http://deliver.jsi.com/2002/Pubs/Pubs_Guidelines/index.cfm					X			X	
Family Planning Manager's Handbook, Chapters 4, 5, 7, 8[c] http://erc.msh.org/mainpage.cfm?file=handbook2.htm&module=enhancement%20other&language=English				X	X			X	
Inreach: Reaching Potential Family Planning Clients within Health Institutions[a] http://www.engenderhealth.org/pubs/workpap/wp5/wp_5.html		X	X				X	X	
The Manager, *Creating a Work Climate that Motivates and Improves Performance*[c]									X
The Manager, *Developing Managers Who Lead*[c] http://erc.msh.org/mainpage.cfm?file=2.1.1.htm&module=leadership&language=English		X							X
The Manager, *Focusing on Customer Service*[c] http://erc.msh.org/mainpage.cfm?file=2.1.1.htm&module=Quality&language=English				X	X	X	X		X
The Manager, *Human Resources: Managing and Developing Your Most Important Asset*[c] http://erc.msh.org/mainpage.cfm?file=2.2.1.htm&module=hr&language=English								X	X
The Manager, *Improving Contraceptive Supply Management*[c] http://erc.msh.org/mainpage.cfm?file=2.5.1.htm&module=Drugs&language=English		X		X	X			X	
The Manager, *Making Your Clinic Building Work*[c] http://erc.msh.org/mainpage.cfm?file=2.1.3.htm&module=Quality&language=English		X			X		X		
Patient Flow Analysis Software[d] http://www.cdc.gov/nccdphp/drh/sata_pfa_ssd.htm					X		X	X	
Performance Assessment Tools[e]			X	X	X	X	X	X	X
PipeLine Monitoring and Procurement Planning System Software[b] http://deliver.jsi.com/2002/Software/Pipeline/index.cfm				X	X				
Population Reports, *Family Planning Programs: Improving Quality*[f] http://www.jhuccp.org/pr/j47edsum.shtml	X		X	X	X	X	X	X	X
Population Reports, *Performance Improvement*[f] http://www.jhuccp.org/pr/j52/j52.pdf			X	X	X	X	X	X	X
QA Monograph: A Modern Paradigm for Improving Healthcare Quality[g] http://www.qaproject.org/pdf/improhq601bk.pdf	X		X	X	X	X	X	X	X
Quality Measuring Tool (QMT)[a]	X	X	X	X	X			X	X
Supply Chain Manager Software[b] http://deliver.jsi.com/2002/Software/SCM/index.cfm				X	X				
Whole-Site Training: A New Approach to the Organization of Training[a] http://www.engenderhealth.org/pubs/workpap/wp11/wp_11.html		X	X					X	X

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